U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

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ELMER C. KINKEAD, Claimant	:	
v	:	
	:	CASE NO: 2000-BLA-01054
CLINCHFIELD COAL COMPANY, Employer	:	
and	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS Party-in-Interest	:	

Before: Stuart Levin
Administrative Law Judge

DECISION AND ORDER

This proceeding arises from a request for modification of a denial by the District Director of a second claim for benefits filed under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.*, and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Mr. Kinkead filed his first claim on August 18, 1987 (DX 31-1) which was denied on December 26, 1989 by Administrative Law Judge B. O'Brien. Judge O'Brien found Claimant had established 30 years of coal mine employment and the presence of pneumoconiosis by the chest x-ray evidence of record and the medical opinion reports of record. Judge O'Brien found, however, that Claimant had not established total disability due to pneumoconiosis. Accordingly, the claim was denied (DX 31-45). Claimant appealed to the Benefits Review Board which affirmed the denial as supported by substantial evidence on July 30, 1991 (DX 31-54). Claimant then appealed to the Fourth Circuit Court of Appeals which dismissed the matter on October 8, 1991 for want of prosecution (DX 31-56).

Claimant filed a second claim for benefits on July 28, 1999 (DX 1). As noted above, the District Director denied this claim based on the prior denial under the provisions of 20 CFR 725.309(d), on October 8, 1999 (DX 18). Claimant did not pursue a hearing on this denial, but

on January 24, 2000, Claimant submitted additional medical evidence (DX 24). The District Director treated this submission as a request for modification. On April 28, 2000, the District Director denied the request for modification (DX 26). Claimant requested a hearing on May 26, 2000 (DX 27).

Initially, a hearing was scheduled for January, 2001, which was continued at Claimant's request. Further hearings were stayed pending litigation concerning the new regulations issued by the Department of Labor in December, 2000. After the stay was lifted, the case was again scheduled for hearing on January 10, 2002. On January 7, 2002, Claimant by letter requested the hearing be canceled and a decision be issued on the record. Claimant's representative stated Claimant is seriously ill and would be unable to attend the hearing. Evidence in the record indicates Claimant is transported to dialysis appointments three times a week by ambulance on a stretcher. Given the serious nature of Claimant's medical condition, Employer agreed at the hearing held on January 9, 2002 to Claimant's request for a decision on the record.

The parties have agreed to the admission of Director's Exhibits 1 through 33 as labeled, Employer's Exhibits 1 through 68 as labeled and identified in various letters submitting these exhibits and Claimant's Exhibits 1 (submitted by letter dated December 9, 2000) and Claimant's Exhibit 2 (submitted by letter dated December 21, 2000)[1] . These exhibits as labeled and identified are entered into evidence.

Duplicate Claims

In cases where a claimant has filed more than one claim and the earlier claim is denied, the later claim must also be denied on the grounds of the earlier denial, unless there has been a material change in conditions or the later claim qualifies as a request for modification under Section 725.310. 20 C.F.R. §725.309(d). The United States Court of Appeal for the Fourth Circuit has held that to determine if a "material change in conditions" has been established, the administrative law judge must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements previously adjudicated against him. *Lisa Lee Mines v. Director, OWCP*, 47 F.3d 402 (1995), *aff'd.*, 86 F.3d 1358 (4th Cir. 1996) (en banc), *cert. denied*, 117 S.Ct. 763 (1997). As noted above, Claimant had established the presence of pneumoconiosis in the prior denial but Claimant had not established total disability due to pneumoconiosis. Accordingly, the favorable and unfavorable probative newly submitted evidence related to whether or not Claimant has subsequently become totally disabled due to pneumoconiosis will be considered to determine if that element previously adjudicated against him has been proven.

Total Disability

[1] Claimant's Exhibit 2 as received by this Office includes the documents referred to in Employer's Brief which Employer stated were included in Claimant's Exhibit 2 and 3.

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A claimant shall be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. If the irrebuttable presumption does not apply, a miner shall be considered totally disabled if he is prevented from performing his usual coal mine work or comparable and gainful work. If the irrebuttable presumption does not apply, and in the absence of contrary probative evidence, evidence which meets the standards under Section 718.204(b)(2) shall establish the claimant's total disability. According to Section 718.204(b)(2), the criteria to be applied in determining total disability include: 1) pulmonary function studies, 2) arterial blood gas tests, 3) a cor pulmonale diagnosis and 4) a reasoned medical opinion concluding total disability.

Pulmonary Function Studies

Pulmonary function study results were submitted for evaluation on the issue of total disability under Section 718.204(b)(2)(i). Assessment of these results is dependent on Claimant's height which was recorded between sixty-nine and seventy-two inches. In the prior denial, Judge O'Brien noted heights of sixty-eight and sixty-nine inches. Considering this discrepancy, I find Claimant's height to be sixty-nine inches for the purpose of evaluating the pulmonary function studies. *Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983). The newly submitted pulmonary function study results are summarized in the table below:

EX. NO.	PHYSICIAN	DATE	AGE	FEV_1	FVC	FEV_1 FVC	MVV
DX 6	Forehand	9-02-99	70	2.09	2.60	80%	54
				2.14	2.90	78%	55
EX 2	Smiddy	12-03-99	70	2.19	2.50	68%	--
EX 34	McSharry	10-12-00	71	1.55	2.22	70%	46
				1.83	2.59	71%	--

Dr. Forehand reported good effort on the pulmonary function study taken on September 2, 1999 (DX 6). Dr. Smiddy reported Claimant's effort and understanding were good, however, several trial were performed but the patient could not get two FEV-1 maneuvers withing 5% due to shortness of breath (EX 2). On the most recent test, Dr. McSharry reported Claimant arrived at the examination on a stretcher and was unable to move around due to his debilitated condition. As a result, the results on the pulmonary function study were not reproducible. Based on the comments of the physicians performing the December, 1999 and October, 2000 pulmonary function studies, I find these studies did not produce valid results. The invalidity is clearly due to Claimant's debilitated condition, including weakness from his prior strokes. The results of the September, 1999 study, however, exceed the regulatory values and, therefore, Claimant has not established total disability under the provisions of subsection 718.204(b)(2)(i) nor has he established a material change in conditions under this subsection.

Arterial Blood Gas Studies

Two new arterial blood gas studies were also submitted for evaluation of total disability under Section 718.204(c)(2). Total disability may be established with arterial blood gas tests which produce values less than or equal to the qualifying values listed in Appendix C to 20 C.F.R. §718. The arterial blood gas test result is summarized in the table below:

EX. NO.	DATE	DOCTOR	pCO_2	pO_2
DX 11	09-02-1999	Forehand	39	79
EX 34	10-12-2000	McSharry	36	64

Both of these studies were taken only "at rest" since Claimant condition did not permit him to perform the exercise portion of a blood gas study. Claimant's values on the September, 1999 are non-qualifying while his values on the October, 2000 blood gas study are qualifying under the regulations. The regulations require that with an arterial pCO_2 of 36 mm Hg., a claimant must demonstrate an arterial pO_2 equal to or less than 64 mm Hg. Claimant's values on the October, 2000 blood gas study, therefore, just meet the minimum requirements of the regulations to qualify. Since the two newly submitted blood gas studies present contradictory results, however, I will consider them in light of the medical opinion reports set forth below. I find these contradictory results are insufficient, standing on their own, to establish that Claimant is totally disabled under the provisions of subsection 718.204(c)(2).

Cor Pulmonale

A claimant may also establish total disability by providing medical evidence of cor pulmonale with right-sided congestive heart failure pursuant to Section 718.204(c)(3). As no medical evidence of cor pulmonale was admitted into the record, I find the Claimant failed to establish total disability with medical evidence of cor pulmonale.

Medical Opinions

The remaining means of establishing a totally disabling respiratory or pulmonary impairment under Section 718.204(b)(2) is with a reasoned medical opinion which concludes total disability is present, if the opinion is based on medically acceptable clinical and laboratory diagnostic techniques. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment". 20 C.F.R. §718.204(c)(4). The newly submitted medical opinion reports are set forth below.

Employer submitted extensive medical records from 1994 through the present regarding Claimant's hospitalization and treatment for various medical conditions. These records document Claimant's cardiac catherization in 1994, ongoing treatment for arteriosclerotic peripheral

vascular occlusion, coronary artery disease, non-insulin dependent diabetes mellitus, cerebral vascular accidents (strokes) in 1992 and 1995, and diverticulitis in records from Dr. H. Turner from 1996 through 2000 (EX 8, 9, 30, 30-33, 35-36). Additional medical records from 1999 and 2000 indicate Claimant was also diagnosed with end-stage renal disease and was being treated with dialysis. Due to his weakened and debilitated condition from cerebral vascular accidents, request was made to have him transported to dialysis by ambulance (EX 32). These various records clearly establish Claimant suffers from a variety of medical conditions.

Dr. J. Forehand examined Claimant on September 2, 1999 and reported normal findings on inspection, palpation and percussion of the chest and lungs with normal breath sounds on auscultation. Dr. Forehand noted Claimant's history of two strokes, renal failure and dialysis as well as his history of coal mine employment and cigarette smoking. He also noted Claimant's had an arterial shunt in the left upper arm and was using a wheelchair at the time of the examination. Dr. Forehand reported no evidence of coal workers' pneumoconiosis on chest -ray, obstructive ventilatory pattern on pulmonary function study and no hypoxemia at rest on blood gas study. Dr. Forehand stated Claimant had no evidence of coal workers' pneumoconiosis, he did have smoker's bronchitis and a pulmonary nodule (as reported on chest x-ray). Dr. Forehand concluded Claimant's pulmonary condition was due to his smoking history and he could perform his ususal coal mine employment with the regular use of a bronchodilator (DX 10).

In a statement dated May 11, 1999, Dr. J. Smiddy, a pulmonary specialist and Claimant's treating physician, concluded Claimant has prolonged shortness of breath due to pneumoconiosis. Dr. Smiddy stated abnormal pulmonary function study results, chest x-ray films and hypoxia on blood gas studies support a diagnosis of pneumoconiosis. In addition, he reported harsh breath sounds with prolonged expiratory phase on physical examination. Dr. Smiddy reported Claimant's pneumoconiosis was treated with bronchodilators and intermittent antibiotics (DX 9). On December 3, 1999, Dr. Smiddy reviewed his progress notes and records. Dr. Smiddy noted his earlier conclusion that Claimant is 100% totally disabled by pneumoconiosis as established by chest x-ray reports. Dr. Smiddy also stated recent pulmonary function study results were not reliable due to Claimant's multiple health problems and he stated Claimant's health made it difficult to travel and attend additional pulmonary testing. On physical examination, Dr. Smiddy reported prolonged expiratory phase with no rales, rubs, rhonchi or wheezes (DX 24). Documents submitted at Claimant's Exhibit 2 appear to be various statements dictated by Dr. Smiddy regarding Claimant's condition which were not prepared for final submission. In these notes, Dr. Smiddy challenged Dr. Forehand's statement that Claimant's condition could improve with the regular use of bronchodilators since Claimant is using bronchodilators regularly (CX 2). Earlier statements dated 1987 and 1988 reiterated Dr. Smiddy's opinion that Claimant is totally disabled by pneumoconiosis (DX 7, 8).

On October 12, 2000, Dr. R. McSharry, a pulmonary specialist, examined Claimant and noted mild hypoxemia on resting blood gas study, evidence of an obstructive disease on chest x-ray with right upper lung scarring most suggestive of old granulomatous disease and no typical pneumoconiotic nodules, and pulmonary function study results which were not reproducible. On physical examination, Dr. McSharry reported the patient arrived on a stretcher and had prolonged expiration and left sided wheezing on physical examination. Dr. McSharry concluded there was

insufficient evidence for pneumoconiosis on laboratory data and physical examination. In particular, he noted the chest x-ray readings were negative which strongly argues against the presence of coal workers' pneumoconiosis. Dr. McSharry then discussed the miner's lung function, noting only a minimal estimate could be made since Claimant's debilitated condition prevented him from performing the pulmonary tests to his fullest ability. Based on the normal lung values and normal diffusion capacity values, Dr. McSharry stated the mild to moderate obstructive lung disease demonstrated on the pulmonary testing was chronic bronchitis rather than emphysema or asthma. He further stated the pattern demonstrated on pulmonary testing was not consistent with coal workers' pneumoconiosis. Dr. McSharry reviewed additional evidence and reiterated his conclusion there is inadequate evidence to diagnosis coal workers' pneumoconiosis. Dr. McSharry noted the miner's pulmonary function testing was normal at the time he left the mines and the subsequent decline was not due to coal mine employment. Dr. McSharry stated the mild to moderate obstructive impairment demonstrated on recent pulmonary testing would not prevent Claimant from performing his ususal coal mine employment. He concluded that even if coal workers' pneumoconiosis were present, his opinions regarding Claimant's pulmonary disability would not change. Dr. McSharry stated Claimant is disabled due to his cardiovascular disease, the results of the two strokes, the renal failure and coronary artery disease, but he also stated that none of these conditions are due to coal mine employment or coal workers' pneumoconiosis (EX 34).

At a deposition taken on December 1, 2000, Dr. McSharry stated Claimant is totally disabled by an airflow obstruction, however, it was his opinion this was not due to coal workers' pneumoconiosis. He stated further there is no evidence to connect the pulmonary test results to coal mine employment or coal workers' pneumoconiosis (EX 62). More recently, on May 23, 2001, Dr. McSharry reviewed Dr. Smiddy's most recent reports (submitted at CX 2 and 3) and noted various problems with the report. Specifically, he noted Dr. Smiddy failed to discuss various pulmonary test results conducted by Dr. Sargent and Dr. Robinette which were non-qualifying and which were taken in the years after the 1987 pulmonary testing upon which Dr. Smiddy relied. He also challenged Dr. Smiddy's reliance upon a symptom of shortness of breath as a basis for concluding a pulmonary limitations are present since several non-pulmonary conditions, including heart disease, anemia, poor conditioning, neurological and rheumatologic disorders can cause shortness of breath. Dr. McSharry also challenged, in some detail, Dr. Smiddy's review and analysis of pulmonary testing conducted by himself (EX 67).

On December 8, 2000, Dr. J. Castle, a pulmonary specialist, reviewed the medical evidence. Dr. Castle concluded there is no evidence of coal workers' pneumoconiosis. He noted Claimant has risk factors for pulmonary disease, including his long exposure to coal mine dust, his long history for cigarette smoking and the presence of coronary artery disease. On physical examination, Dr. Castle noted crackles and rales were reported intermittently which is consistent with cardiac changes in the lungs. In addition, he noted pulmonary function study test results were normal when valid and blood gas studies were essentially normal with normal response to exercise. On the most recent blood gas study, he agreed Claimant had demonstrated mild hypoxemia which he stated is to be expected given Claimant's multiple medical problems.

Dr. Castle stated Claimant has no significant respiratory impairment based on the previous valid pulmonary testing, and if an airway obstruction is present, it is due to smoking. He agreed Claimant is totally disabled by his multiple medical problems, including coronary artery disease, congestive heart failure, end stage renal disease with renal failure, and previous cerebral vascular accidents. Dr. Castle stated that even if radiographic coal workers' pneumoconiosis were present, his opnion regarding Claimant's disability would be the same, his opinions regarding Claimant's disabilities were not dependent on negative chest x-ray reports (EX 61).

In a report dated December 20, 2000, Dr. Castle reviewed additional evidence. The findings on CT scan by Dr. Westerfield did not change Dr. Castle's opinions regarding Claimant's pulmonary condition (EX 64). On May 31, 2001, Dr. Castle reviewed the newest reports prepared by Dr. Smiddy and stated they did not change his opinion. Dr. Castle challenged Dr. Smiddy's reliance upon the symptom of shortness of breath agreeing with Dr. McSharry's statement that shortness of breath can be caused by many non-pulmonary conditions, including cardiac disease, previous cerebrovascular accident, renal failure and other disease that are present in this claimant. Dr. Castle also challenged Dr. Smiddy's reliance upon the invalid recent pulmonary function study which Claimant clearly was not able to perform adequately due to his multiple medical problems. He also challenged Dr. Smiddy's reliance upon invalid pulmonary function study results from December, 1987 while ignoring valid and non-qualifying pulmonary function study results from September, 1987 and November, 1988. Pulmonary function study results from 1999 and 2000 were taken after the cerebrovascular accidents in 1992 and 1995 (strokes) and were, therefore, invalid because of less than maximal effort and lack of reproducibility, clearly related to Claimant's debilitated and weakened condition following the strokes. Dr. Castle also discussed the most recent blood gas study of October, 2000 which showed mild degree of hypoxemia. Dr. Castle noted this hypoxemia (demonstrated in 2000) developed after 1999, when Claimant demonstrated normal values on blood gas testing. Dr. Castle explained during the interval between the tests, Claimant also was treated for congestive heart failure, severe cardiac disease, renal failure requiring dialysis, diabetes, and the previous cerebrovascular accidents. There is no evidence that there is any relationship between this hypoxemia and his previous coal mine employment or coal workers' pneumoconiosis. Furthermore, there is no evidence of any relationship between Claimant's serious cardiac condition, diabetes and renal failure and his coal mine employment or coal workers' pneumoconiosis. Dr. Castle explained his opinion would not change even with pneumoconiosis of a profusion of 1/0 or 1/1 since Claimant had no physiologic pulmonary impairment until after he sustained the significant cerebrovascular accident (EX 68).

On consideration of these newly submitted medical opinion reports, I find the reports by Drs. Forehand, McSharry and Castle most persuasive. These physicians discussed the Claimant's complex medical condition in detail and included specific reasons for their conclusion that Claimant's disability is not related to any pulmonary condition due to pneumoconiosis or coal mine employment. In particular, Dr. McSharry and Dr. Castle, both highly qualified as pulmonary specialists, discussed the history of pulmonary testing as well as Claimant's medical history in determining that the test results do not establish any disability due to pneumoconiosis. Both these physicians agreed pneumoconiosis had not caused Claimant any pulmonary disability, even if

present radiographically, based on the pattern shown on recent pulmonary testing, the fact that earlier pulmonary testing was non-qualifying, as well as the history of Claimant's medical problems, including the prior strokes, diabetes, renal failure and cardiac condition, and the pattern of test results before and after other medical conditions arose.

In contrast, Dr. Smiddy relies upon older invalidated pulmonary test results and his own general statements over the years that Claimant is totally disabled due to pneumoconiosis. Since Dr. Smiddy's earlier opinions were not well supported, as determined by Judge O'Brien, his new opinions are likewise not well supported since they rely upon the earlier test results and medical reports. Dr. Smiddy notes Claimant's multiple medical problems, but he does not discuss them with the detail Dr. McSharry and Dr. Castle discuss these conditions nor does he discuss their effect on Claimant's pulmonary condition. Dr. Smiddy's general statements are not sufficient to outweigh the well reasoned and well supported reports of Drs. Forehand, McSharry and Castle. As Dr. Smiddy treated Claimant, I must consider his opinion pursuant to §718.104(d). This new regulation in effect states that a treating physician's opinion shall be accepted "in the absence of contrary probative evidence" and may be given controlling weight if it is credible "in light of its reasoning and documentation, other relevant evidence and the record as a whole." §718.204(d)(5). In light of the contrary probative evidence, however, and in light of the absence of any reasoning or documentation to support the Dr. Smiddy's general statements that Claimant is totally disabled due to pneumoconiosis, I do not "accept" the opinion of Dr. Robinette, nor do I give controlling weight to his opinion. Accordingly, I find the probative weight of the newly submitted medical opinion reports does not establish total disability due to pneumoconiosis under the provisions of subsection 718.204(b)(2)(iv).

While the newest blood gas study did qualify under the provisions of subsection 718.204(b)(2)(iii), on consideration of all of the evidence of record, I find that qualifying study is outweighed by the other medical evidence of record. Specifically, I credit the reports of Drs. McSharry and Castle which examine the history of pulmonary testing in this matter and conclude the results of the 2000 blood gas study were not due to pneumoconiosis but were due to other medical conditions.

Thus, I find Claimant has not established total disability under the provisions of subsection 718.204(b)(2) since he has not established a totally disabling respiratory or pulmonary impairment. Furthermore, Claimant has not established total disability due to pneumoconiosis under the provisions of subsection 718.204(c) since he has not shown that pneumoconiosis is a substantially contributing

cause of his weakened and debilitated state which is due to his cardiac disease, renal failure and dialysis, and prior cerebrovascular accidents in 1992 and 1995.

Accordingly, Claimant has not established total disability due to pneumoconiosis , the element of his claim previously adjudicated against him. Therefore, he has not demonstrated any change in condition since the prior denial. This claim must, therefore, be denied on the basis of the prior denial as provided in Section 725.309(d). Moreover, on consideration of all of the

evidence, I note that the claim for benefits would also be denied on the merits since the evidence considered in total does not establish total disability due to pneumoconiosis. Accordingly, this claim for benefits shall be denied.

CONCLUSION

Since Claimant has not established a totally disabling pulmonary condition which arose out of coal mine employment or was due to pneumoconiosis, he has not established entitlement to benefits under the Act. In addition, he has not established any basis for modification of the denial of benefits issued on October 8, 1999 by the District Director. Accordingly,

ORDER

IT IS ORDERED that the request for modification of the denial of benefits is denied.

IT IS FURTHER ORDERED that the claim of Elmer C. Kinkead for benefits under the Act shall be denied.

A
STUART A. LEVIN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Francis Perkins Bldg., Room N-2117, 200 Constitution Ave., N.W., Washington, D.C. 20210.